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Committee on Economic, Social and Cultural Rights
UNOG-OHCHR
CH-1211 Geneva 10
Switzerland

6 September 2019

Re: Information for the periodic review of Denmark by the Committee on Economic, Social and Cultural Rights during its 66th session

Distinguished Committee members,

In its list of issues in relation to the sixth periodic report of Denmark, the Committee on Economic, Social and Cultural Rights has requested information from the State party on "any measures taken to address the barriers preventing unregistered migrants from properly accessing the health-care services to which they are entitled, including … maternity care." In its responses, the State party asserts that undocumented migrants are "adequately covered" by the Danish health care system. It notes that "non-residents have access to emergency hospital treatment and subsequent non-emergency hospital treatment in cases, where it is not considered reasonable to refer the person to treatment in their home country." It further points out that no payment will be charged for "acute births".

However, in practice, contrary to the State party's submission, many undocumented migrant women in Denmark are unable to access maternal health care throughout pregnancy and childbirth due to a range of financial and legal and policy barriers. As a result of these legal and policy barriers, Denmark is failing to ensure that undocumented migrant women can enjoy the right to the highest attainable standard of health under Article 12 of the International Covenant on Economic, Social and Cultural Rights without discrimination.

The Center for Reproductive Rights' recent report entitled Perilous Pregnancies: Barriers in Access to Affordable Maternal Health Care for Undocumented Migrant Women in the European Union, which is enclosed, outlines the relevant legal provisions regulating access to maternal health care for undocumented migrant women in Denmark (p. 38-39). As explained there, while

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Danish law does provide that individuals without legal residency are entitled to emergency medical treatment, "in case of accident, sudden illness and birth, or worsening of chronic disease etc.",[1] in fact recent Danish Ministry of Health guidance stipulates that when a woman gives birth at term (within 37-41 weeks of pregnancy) this is not an emergency and does not fall under the legal entitlement to receive free emergency medical treatment. This highly restrictive policy combined with laws and policies that do not entitle undocumented migrant women to access free or subsidized antenatal care, means that in practice Danish law and policy prevents many undocumented migrant women from accessing maternal health care during pregnancy and childbirth.

First, as outlined in the report (p. 39), undocumented migrant women are not entitled to any cost coverage for antenatal care during pregnancy and must pay the full cost of such care out of pocket. As a result, many undocumented migrant women in Denmark do not access adequate antenatal care. Antenatal care is critical for detecting and treating health conditions such as anaemia, hypertension, or bleeding, which, when left undetected, expose pregnant women to pregnancy related complications and heightened risks of including premature birth, miscarriage, severe disabilities or chronic illnesses, and death.[2] The World Health Organization has underlined that insufficient or delayed access to antenatal care exposes women to higher risks of maternal mortality and morbidity.[3]

Second, some undocumented migrant women in Denmark will be charged the full cost of medical assistance during childbirth. As stated above, recent Danish Ministry of Health guidance stipulates that when a woman gives birth at term (within 37-41 weeks of pregnancy) this is not an emergency and does not fall under the entitlement to receive free or subsidised emergency medical treatment.[4] As a result, undocumented migrant women who give birth at term do not qualify for free or subsidised maternal health care during labour and childbirth.[5] While hospitals may waive these charges if they deem it reasonable, this is discretionary,[6] and therefore undocumented migrant women who give birth at term risk being billed for the full, and very high, costs of care during childbirth.

Furthermore, even for those undocumented migrant women who appear to be facing an obstetric emergency or other health crisis during pregnancy, in the absence of Ministry of Health guidelines, what constitutes an emergency may be construed narrowly by health care providers thereby excluding undocumented migrant women from cost coverage for certain maternal health care. For example, the need for a woman to undergo caesarean section may not always be considered to constitute emergency care, and as a result, undocumented migrant women who

require caesarean sections may encounter difficulties in finding hospitals willing to schedule the procedure if they are unable to cover the costs.[7]

Excluding undocumented migrant women from access to affordable maternal health throughout pregnancy and delivery also negatively impacts the quality of care they receive. For example, there have been reports that undocumented migrant women in Denmark have been discharged earlier than usual from health care facilities after birth because of concerns about their ability to pay the costs of a longer stay.[8] The WHO recommends that the minimum duration of stay in a health facility following childbirth is 24 hours, and undocumented migrant women's early discharge or departure can give rise to considerable concerns, not least because the risk of maternal death is highest in the 48 hours following childbirth.[9]

As the Committee has repeatedly affirmed Article 12 requires States parties to guarantee women's enjoyment of the right to the highest attainable standard of health, and to ensure all women have access to affordable and quality maternal health care throughout pregnancy and childbirth, including early, regular, and appropriate antenatal care; skilled birth attendance; and emergency obstetric care.[10] As a result, States parties are required to ensure that all undocumented migrant women can access affordable and quality maternal health care throughout pregnancy. State failures to ensure access to affordable maternal health care, including antenatal care, violate minimum core obligations to ensure the right to the highest attainable standard of health.[11] Furthermore, the Committee has acknowledged that undocumented migrant women are often particularly marginalized and exposed to intersectional discrimination which requires States parties to take particular and targeted measures to ensure their effective access to reproductive health care.[12]

We hope that the Committee will take this information into consideration when examining Denmark's compliance with its obligations under the Covenant to guarantee the right to the highest attainable standard of health for all, including undocumented migrant women. In particular we hope that the Committee will consider making the following recommendations to the State party:

- Reform laws and policies on access to free or subsidized antenatal care for undocumented migrant women and allow these women to obtain free or subsidized care, including antenatal care.
- Repeal Ministry of Health guidelines restricting access to free maternal health care for undocumented migrant women to "acute births".

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- Issue Ministry of Health guidelines specifying broad interpretation of entitlements to free emergency care for undocumented migrant women to encompass all forms of maternal health care in connection with childbirth.
- Ensure that entitlements to affordable maternal health care are accessible in practice by removing any legal, administrative, language, and cultural barriers that impede undocumented migrant women's access to affordable maternal health care throughout pregnancy and delivery.

We hope this information is useful to the Committee's examination of Denmark's compliance with the Covenant.

Sincerely,

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[1] Sundhedsloven [Healthcare Act], L.B.K. nr 913 af 13/07/2010, art. 8(1), (Dk.), *available at* https://bit.ly/2oj9BVe; Bekendtgørelse om ret til sygehusbehandling m.v. [Executive Order on the right to hospital treatment], art. 5(1), *available at* https://bit.ly/2MDXNH6.
[2] Ligia Moreira Almeida ET. AL, *Assessing maternal healthcare inequities inequities among migrants: a qualitative study*, 30 CADERNOS DE SAÚDE PÚBLICA 2, 326 (2014).
[3] WHO, RECOMMENDATIONS ON ANTENATAL CARE FOR A POSITIVE PREGNANCY EXPERIENCE, 105 (2016).
[4] *See* MINISTERIET FOR SUNDHED OG FOREBYGGELSE, SUNDHEDSYDELSER TIL UREGISTRERERE MIGRANTER [MINISTRY OF HEALTH AND PREVENTION, HEALTHCARE FOR UNREGISTERED MIGRANTS], *available at* https://bit.ly/2IN8vc0; Executive Order on the right to hospital treatment, art. 5(1), (delivery at term is considered from week 37 to week 41 +6).
[5] *See* MINISTERIET FOR SUNDHED OG FOREBYGGELSE, SUNDHEDSYDELSER TIL UREGISTRERERE MIGRANTER [MINISTRY OF HEALTH AND PREVENTION, HEALTHCARE FOR UNREGISTERED MIGRANTS], 6 (in a case concerning a pregnant Serbian woman who is married to a Danish man and who was seeking family reunification at the time of giving birth, the Patient Safety Board held that the regional authority's charging of costs for the delivery, which took place at term, was reasonable under the circumstances. The Board considered that since the delivery occurred at term the hospital treatment was not urgent, and that the needed care could have been anticipated by the woman and her husband. It also considered that there was nothing to indicate that the woman could not have travelled to Serbia to deliver. The Board also found that the decision to charge for the cost did not breach administrative principles of equal treatment. *See* https://bit.ly/2PLGsyw).
[6] Executive Order on the right to hospital treatment, art. 5(1).
[7] Center for Reproductive Rights, Perilous Pregnancies: Barriers in Access to Affordable Maternal Health Care for Undocumented Migrant Women in the Euoropean Union, 28 (2019).
[8] Danish Institute for Human Rights, *Uregistrerede migranters sundhedsrettigheder: Fokus på gravide og børn*, 28 (2016).
[9] WHO, US AID, CHIP, MATERNAL AND CHILD SURVIVAL PROGRAM, POSTNATAL CARE FOR MOTHERS AND NEWBORNS, HIGHLIGHTS FROM THE WORLD HEALTH ORGANIZATION 2013 GUIDELINES (2015).
[10] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); Committee on Economic, Social and Cultural Rights, *General Comment No. 22: On the right to sexual and reproductive health (Art. 12)*, U.N. Doc. E/C.12/GC/22 (2016); OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS, HUMAN RIGHTS-BASED APPROACH TO REDUCE PREVENTABLE MATERNAL MORBIDITY AND MORTALITY: TECHNICAL GUIDANCE, *available at* https://bit.ly/2wnieTd; United Nations General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 13, U.N. Doc. A/61/338 (13 September 2006).
[11] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), para. 50, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); Committee on Economic, Social and Cultural Rights, *General Comment No. 22: On the right to sexual and reproductive health (Art. 12)*, para. 51, U.N. Doc. E/C.12/GC/22 (2016); Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).
[12] Committee on Economic, Social and Cultural Rights, *General Comment No. 22: On the right to sexual and reproductive health (Art. 12)*, para. 31, U.N. Doc. E/C.12/GC/22 (2016).

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